Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000723	A. BUILDING: ______ B. WING ______	04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-CARLINVILLE	1200 UNIVERSITY AVENUE CARLINVILLE, IL 62626

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210b)4) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/28/16

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provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on interview, observation and record review, the facility failed to assess/monitor and

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develop a plan to address gradual weight loss and failed to provide needed assistance in eating for 2 of 6 residents (R3, R13) reviewed for nutritional status and weight loss in the sample of 17. This failure resulted in an unplanned significant weight loss and a decreased albumin level for R3.

Findings include:

1. The Minimum Data Set (MDS), dated 2/17/16, identifies R3 as having severe cognitive impairment. The MDS documents R3 requires extensive assist of one staff for eating.

R3's Weight loss records document a gradual weight loss of 18 pounds from 9/15/15 at 158.8 pounds to 140.2 pounds on 3/5/16 which is an 11% weigh loss within 6 months.

R3's Care Plan, dated 2/10/16, identifies a nutritional focus dated 7/15/15 documents "(R3) is within her desired body weight range of 111.0-157.00 pounds. She resides on the secured unit and eats in the Oakwood dining room. She is independent with eating but does require assistance at times." The Goal is: Maintain current weight through next review - target dated 3/22/16 with two interventions. The first is to ensure that R3 has her glasses on at mealtime, dated 2/4/16, and provide LCS (Low Concentrated Sweet) diet with regular texture and consistencies with no changes or revisions as of 4/7/16.

On 4/5/16 at 12:01 PM, R3 received her lunch tray from E8, Certified Nurse Aide (CNA). R3 was sitting at the circular assist table. R3 did not have her eye glasses on. R3 had ground meat with gravy, mashed potatoes with gravy, and corn in a

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divided plate. R3 also received a glass of tea and water, but no milk even though it was listed on the menu. R3 sat and poked at her meal with no assistance and/or cueing or encouragement provided. No interventions were offered such as verbal cueing, encouragement or substitutions offered as she sat in front of her meal. At 12:50 PM, R3 backed her wheelchair up and when asked if she was done by E8, rolled herself out of the dining room to the activity room. She ate 50% of her meat, no potatoes or dessert bar, and less than 25% of the corn.

On 4/6/16 at 12:15 PM, R3 received ground fish, cream noodles, tomato/zucchini salad in a divided plate and a small bowl of fruit cocktail and a 1/2 piece of bread pudding from E13, CNA. R3 was again sitting at the assist table. R3 picked up her spoon and attempted to eat the fruit, dropping it into her salad and fish and onto the tray. R3 attempted to spoon up the bread pudding, then picked it up with her fingers and ate it. R3 struggled as she attempted to put food onto her spoon, and then set the spoon down and stated she was done. E13 asked R3 if she wanted any more, but failed to offer assistance, cueing, encouragement or substitutions for food uneaten. R3 left the table. The food on R3's divided plate was all mixed up. R3 ate none of her fish that had fruit on it, no noodles, 50% of the tomato/zucchini salad, 100% of the bread pudding and only about 50% of her fruit which was mostly on her tray.

A Quarterly Note, dated 12/28/15 by E4, Dietary Manager (DM), documents that R3's weight was 158.3 pounds on 12/5/15, Albumin level was 3.4 Low, and a gradual weight loss had been noted. On 2/18/16, E4's significant change note documented R3's Albumin level to be 3.2 Low

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and that R3 "seemed to be having difficulty processing some meats. Her present diet will likely be downgraded to mechanical textures." R3's weight recorded then was 143.3, 30 day from 159.4 and six month 156.7. There is no documentation regarding any changes to R3's plan of care in an effort to increase her intake and maintain her weight.

On 4/7/16 at 12:45 PM, a Registered Dietician's (RD) Assessment was requested from E2, Director of Nurses. A one page "Dietary Recommendations for physician approval," dated 2/14/16 written by E10, RD, was provided which documents R3's weight to be down, appetite poor/fair with recommendations to add MedPass 60 cc (cubic centimeters) TID (three times daily.) There is no documentation that E10 evaluated or assessed R3 and her weight loss including a decline in functional ability or possible increased need for assistance/verbal cueing/encouragement in eating.

An additional RD Note, dated 3/14/16 by E10, documents "Sig wt (Significant weight) change note for resident c (with) wt (weight) 3/5/16 140 # (pounds), weight fairly stable since RD last note, Reg (Regular) diet ordered and oral supplements initiated 2/29. Appetite/intake fair. No new labs and no skin concerns or edema noted. Will continue to monitor for wt stability w (with)/adequate intake of food/supplements. No changes at this time." There is no indication in this note that the dietician assessed R3's functional ability for decline or the need for increase assistance including verbal cueing/encouragement or substitutions for food uneaten.

On 4/7/16 at 2:11 PM, E12, Registered Nurse

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(RN), stated R3 takes her Medpass Supplement about 50% of the time and refused it at lunch earlier. E12 stated that nurses document whether R3 takes it or not on the Medication Administration Record (MAR.)

On 4/7/16 at 2:20 PM, E1, Administrator, stated R3's weight problem started with a fractured hip in January 2016. However, monthly weight sheets document R3's weight on 1/26/16 with readmission to the facility following the fracture was 156 pounds and subsequent weights document gradual decrease in weight. R3's weight on 2/5/16 was 145.4, 2/9/16 143.3, 2/23/16 121.3 and on 3/5/16, 140.2 pounds.

In addition, there is no change/addition and/or revisions to the Care Plan since 2/4/16 when they added the eye glass interventions. Dietary failed to develop a nutritional plan to reflect R3's weight loss risk, subsequent loss and need for increased assistance and/or verbal cues/encouragement.

2. R13' MDS, dated 1/18/16, identifies R13 to have severe cognitive impairment and requires minimal assist of one staff for eating.

R13's Care Plan, dated 1/27/16, documents under the Focus area that R13 is within his desired body weight range of 129-183 pounds, resides in the secured area of the facility, has upper and lower dentures, but refuses to wear them. The goal is to maintain weight +/- 3 pounds through next review. Interventions include providing regular diet with regular textures and consistencies, and offer a soft protein alternative when having difficulty chewing meat.

On 4/5/16 at 12:03 PM, R13 received his lunch meal and received meat loaf, potato/gravy and

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asked if he was having difficulties eating and he said "yes." E1 then offered to assist and R13 allowed E1 to feed him bites of food. E1 assisted for a short while then left to get the therapist. A short time later, E16, Certified Occupational Therapy Assistant, came into the dining area and asked R13 if he was having difficulty feeding himself to which he responded "yeah." E16 then cued him to eat and he picked up a bite. E16 then turned around, left the dining room stating "He just needed to get going, I think he's okay." No soft protein alternative was offered as indicated in the Care Plan.

The weight records show a gradual decline of 13.4 pounds or 9% since 10/22/15 for R13. The records document R13's weight as 141.1 pounds on 10/22/15 and 127.7 pounds on 3/5/16. R13's Dietary assessement, dated 1/21/16 by E4, DM, documents that R13's albumin is low at 3.0, he's independent in eating and has "no issues at this time" although he'd already lost 9 pounds in three months (141.1 to 132.3) according to R13's weight record. No additions or revisions have been done to the Care Plan in an effort to maintain R13's weight and prevent further loss. There has been no assessments towards his weight loss in regards to functional decline and/or increased needed assistance except on 2/24/16 when a supplement was initiated which is also not on the Care Plan.
(B)